

# Town and Country Pediatrics

# Family History Questionnaire

Note: Only one copy of this page needs to be filled out per family. We will place a copy in each chart.

Today's Date: \_\_\_\_\_

Person Filling Out This Form: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

List each Child's Name and Birthdate:


Please check the boxes where child's blood relatives have any of these problems:

	Father	Mother	Brother	Sister	Father's Side	Mother's Side
Allergies (Asthma, Eczema, Hay Fever)						
Birth Defects (Cleft Lip, Club Foot, Hip Dysplasia)						
Blood Disorders (Bleeding, Sickle Cell, Anemia)						
Bone/Joint Disorders (Arthritis, Gout)						
Cancer (Leukemia, Breast Cancer, Tumors)						
Cholesterol Problems						
Diabetes						
Eye Problems ( Blindness, Lazy Eye, Crossing Eyes)						
Ear Problems(Deafness/Hearing Aids)						
Gastrointestinal Disorders (Ulcer, Crohn's, Celiac)						
Genetic Disorders (Down Syndrome, Cystic Fibrosis)						
Heart Disease (Heart Attacks, High Blood Pressure)						
Kidney Disease (Absent Kidneys, Cystic Kidneys)						
Lung Disorders (Asthma, Tuberculosis)						
Muscle Disorders (Multiple Sclerosis, Stiffness)						
Nervous Disorders (Migraines, Seizures, Epilepsy)						
Psychiatric Disorders (Depression, Suicide, Schizophrenia)						
Thyroid Problems						
Venereal Diseases (Syphilis, Gonorrhea, HIV, Herpes)						
Alcoholism, Drug Dependency						
Regular Smoker						
Other:						

The following information is of value in the complete examination of your child.

ANSWERING IS OPTIONAL AND OF COURSE CONFIDENTIAL!

	Yes	No
Are there any problems at home we should be aware of ?		

Have parents been divorced or separated?  Yes  No

Children reside with \_\_\_\_\_